U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 21 June 2007

In the Matter of:

J. O.,
Claimant,

CASE NO: 2005-BLA-5992

v.

ISLAND CREEK COAL COMPANY,
Employer,

and

WESTMORELAND COAL COMPANY c/o
ACORDIA EMPLOYERS SERVICE
Carrier,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest.

Appearances:

J. Todd Ross, Esq.
For the Claimant

Douglas Smoot, Esq.
For the Employer

Before: LARRY W. PRICE
Administrative Law Judge

DECISION AND ORDER – DENYING BENEFITS

This matter arises from a claim for benefits under the Black Lung Benefits Act, Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. 901 *et seq.* (Act), and applicable Federal Regulation, mainly 20 C.F.R. Parts 412, 718, and 725 (Regulations).

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to coal workers' pneumoconiosis (CWP) or to the survivors of persons whose death was caused by coal workers' pneumoconiosis. Coal workers' pneumoconiosis is defined in the Act as "a chronic dust disease of the lung and its sequelae, including pulmonary and respiratory impairments, arising out of coal mine employment." 30 U.S.C. 902(b).

On June 6, 2005, this case was referred to the Office of Administrative Law Judges for a formal hearing. The hearing was held in Abingdon, Virginia on October 26, 2006. At the trial I admitted Director's exhibits 1 through 26, to the extent that they comply with the evidentiary limitations at 20 C.F.R. § 725.414 (2004); CX[1] 1, 2 and 4 through 7; EX 1 through 14.[2] I identified the Claimant's evidence summary form as ALJ 1, and Employer's evidence summary form as ALJ 2.[3]

ISSUES

The following issues remain for resolution:

- Existence of pneumoconiosis.
- Whether pneumoconiosis arose from coal mine employment.
- Whether Miner has a totally disabling pulmonary impairment.
- Whether total disability was caused by the pneumoconiosis.

[1] The following abbreviations have been used in this decision: DX – Director's Exhibit; EX – Employer's Exhibit; CX – Claimant's Exhibit; TR – Transcript of the January 10, 2006 hearing; BCR – Board certified radiologist; and B – B-Reader.

[2] Claimant objected to the admission of EX 13 and 14. Claimant submitted two interpretations of the same x-ray as initial evidence. The Employer offered two interpretations of that one x-ray study as rebuttal evidence. Claimant contends that since there is only one x-ray, Employer should only be able to rebut it with one interpretation. By published decision in Ward v. Consolidation Coal Co., 23 B.L.R. 1-151 (2006), the Board held that, under § 725.414, each party is entitled to submit one x-ray *interpretation* for each x-ray *interpretation* offered by the opposing party. Therefore, I admitted EX 13 at the hearing. Claimant objected to EX 14, which is a CT scan offered by Employer as rebuttal evidence. In Webber v. Peabody Coal Co, 23 B.L.R. 1-123 (2006)(en banc) (J. Boggs, concurring), the Board noted that the amended regulatory provisions at § 725.414 do not provide specific limitations to the admission of evidence under 20 C.F.R. § 718.107. Nevertheless, in Webber, the Board adopted the Director's position that "the use of singular phrasing in 20 C.F.R. § 718.107" requires that "only one reading or interpretation of each CT scan or other medical test or procedure to be submitted as affirmative evidence." I read this decision to mean that each party, both Claimant and Employer, may submit a CT scan interpretation as initial evidence. This does not bar either party from offering a CT scan interpretation as rebuttal for the interpretation offered by the opposing party as initial evidence. I therefore admitted EX 14 at the hearing.

[3] Following the hearing, Claimant requested the return of CX 2, 4 and 5. Those exhibits were his only copies; the exhibits were attached to the Claimant's brief and returned on March 28, 2007. Employer's attorney filed a motion to strike late evidence via fax on June 12, 2007. Employer noted that the last two pages of CX 4 is a report from Dr. Smiddy, dated April 11, 2005, which was not admitted at the hearing and had never previously been exchanged with Employer. I agree with Employer and strike Dr. Smiddy's April 11, 2005 report.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The parties have stipulated to the following issues, and I therefore find the following facts:

- That Claimant, hereinafter referred to as Miner, is a miner as defined by the Act and was employed as a coal miner for 28 years. (Tr. 6).
- That Claimant's wife is recognized as a dependant under the Act. (Tr. 31)

Procedural History

Miner filed the present claim for Black Lung benefits on August 9, 2004.[4] (DX2). On April 15, 2005, a Proposed Decision and Order was issued awarding claimant benefits under the Act. (DX 17). Employer requested a formal hearing.

Background

Miner was born on August 21, 1937 (DX 2) and currently lives in Mt. Carmel, Tennessee. (Tr. at 20). He married his wife on December 16, 1961. (DX 2). They are still married. (DX 2). Miner does not have unmarried children under the age of 18, disabled or between 18 and 23 and attending school. (DX 2). Miner has a seventh grade education. (DX 2). Miner reports working numerous positions in the mines, including miner operator, tipple mechanic, fine coal operator and preparation plant operator. (DX 2).

The record contains varied statements regarding the Miner's smoking history. Miner testified that he had smoked approximately half a pack per day for 37 years. He also admitted to occasionally smoking an entire pack in one day. (EX 8 at 27). Dr. Rasmussen listed a smoking history of half a pack per day for 39 years. (CX 1at 2). Dr. Girish reported a smoking history of one pack per day for 37 years. Dr. Castle noted a 35 pack year smoking history. (EX 1 at 1). Dr. Hippensteel's report listed a smoking history of one half pack per day for 37 years. Dr. Smiddy reported that Miner smoked for 43 years, but does not specify the number of cigarettes per day. Drs. Castle and Girish listed a smoking history in excess of 35 pack years. Drs. Rasmussen and Hippensteel estimated a smoking history of approximately19 pack years. Miner himself reported smoking at least half a pack per day for 37 years, but did admit to smoking a pack per day on occasion. The average smoking history would be one pack per day for 27 years; therefore I find that Miner has a 27 pack year smoking history.

Timeliness

Under § 725.308(a), a claim of a living miner is considered timely if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. Section 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. Because the record contains no evidence that Claimant received

[4] In his brief, Claimant reported filing "the present claim for Black Lung benefits on July 3, 2002, which was withdrawn according to [his] prerogative."

the requisite notice more than three years prior to filing of his initial claim or any subsequent claim for benefits, I find that his claim was timely filed.

Responsible Operator

In order to be deemed the responsible operator liable for the payment of benefits, an employer must have been the last employer in the coal mining industry for which the miner had his most recent period of coal mine employment of at least one year, including one day after December 31, 1969. 20 C.F.R. §§ 725.492(a), 493(a) (2004). The regulatory amendments at 20 C.F.R. §725.495(c)(2) (2001) require that the designated responsible operator establish "[t]hat it is not the potentially liable operator that most recently employed the miner." The Social Security Records show that Claimant's last full year of coal mine employment was in 1998 at Island Creek Coal Company. (DX 6). Therefore, I find that Island Creek Coal Company is properly named as the responsible operator in this claim.

Miner's Testimony

Miner was deposed on November 17, 2005. Miner testified that he had been receiving Social Security disability benefits, in the amount of approximately fifteen hundred dollars, for five or six years for his arthritis and lungs. Miner described the duties involved in his last job with Employer. He testified that his final job was preparation plant operator. The preparation plant was a big open space that often filled with coal dust. Miner would have to clean the plant roughly once a month. Cleaning the plant was a very labor intensive and dusty job. On a good day, Miner would sit at an operation desk running a control panel of buttons. Even on a good day, Miner testified that he would only be able to sit between two and three hours a day. Miner testified that part of his job included aiding the mechanics when any machine would break. He would have to shovel coal if any spilled. On occasion, Miner had to change belts and screens out of the low head vibrators. Changing screens entailed lifting 85 pounds at a time. (EX 8 at 11 – 15).

Miner sought treatment from his family doctor, Dr. Carroll, for the past two years. (EX 8 at 21). Miner had received treatment for his pulmonary problems from Dr. Ioso. He then moved and started treatment for his lungs from Dr. Smiddy two years ago. (EX 8 at 22). Miner testified that Dr. Smiddy performed a bronchoscopy and then informed Miner that he had black lung and some bronchitis, though not critical or chronic in nature. At the time of the deposition, Miner had been using oxygen for approximately a month. (EX 8 at 25). Miner testified that he didn't really start smoking until 24, and then approximately half a pack per day, although he would smoke an entire pack per day on occasion. He stated that he quit seven or eight years ago. (EX 8 at 27).

MEDICAL EVIDENCE

X-ray Reports

Exhibit	Doctor	Qualifications	Date of X-ray	Date of	Film Quality	Interpretation

				Reading		
CX 1	Rasmussen	B	2/23/06	2/24/06	1	1/0, q/s
CX 2	Westerfield	B/BCR	2/23/06	4/07/06		1/1, q/r (report also indicates that there are no "pleural plaques or pleural calcifications to suggest pneumoconiosis/ asbestosis.")
EX 12	Wiot	B/BCR	2/23/06	9/26/06	3	No CWP
EX 13	Spitz	B/BCR	2/23/06	9/28/06	3	No CWP
EX 3	Hippensteel	B	6/8/05	6/9/05	1	No CWP
EX 1	Castle	B	2/22/05	3/4/05	1	No CWP
DX 10	Girish		9/29/04[5]	10/04/04		1/2, u/u[6]
EX 2	Wiot	B/BCR	9/29/04	1/25/05	2	No CWP, aa[7]
CX 4	Smiddy		5/28/04	5/28/04		"chest x-ray today shows slight prominence of markings in the lingula with evidence of pneumoconiosis"

Pulmonary Function Studies[8]

Exhibit #	Physician	Date of Study	Tracings Present?	Flow-Volume Loop?	Broncho-dilator?	FEV1	FVC/ MVV	Age/ Height	Qualify?	Coop and Comp. Noted
CX 1	Rasmussen	2/23/06	Yes	Yes	Yes	B 1.93/ A 2.28	B 3.63/ A 4.38	68/68	no	No
CX 4	Smiddy	6/08/04	Yes	Yes	Yes	B 1.67/ A 2.12	B 3.15/ A 3.55	67/69	yes	Yes
DX 10	Girish	9/29/04	Yes	Yes	No	1.49	2.46/ 68	67/69	yes	No
EX 1	Castle	2/22/05	Yes	Yes	Yes	B 1.78/ A 2.03	B 3.44/ 69 A 3.80	67/68	yes	Valid Studies.

[5] There are two different x-ray reports attached to the Department of Labor exam, one dated September 29, 2004 and the other dated October 4, 2004. The ILO form dated October 4, 2004 was received in November 2004. The date on the ILO form was corrected, i.e. changed from October 4, 2004 to September 29, 2004, and faxed to the Department of Labor on April 15, 2005.

[6] Dr. Girish circled two different profusion categories, 1/2 and 2/1, on the ILO form.

[7] atherosclerotic aorta

[8] 20 C.F.R. 718 Appx. B establishes the standards for the administration and interpretation of pulmonary function tests.

EX 3	Hippensteel	6/8/05	Yes	Yes	No	B 1.94/ 2.01	B 3.65/70 A 3.55	67/68	no	Yes; MVV test invalid (EX 5)

Arterial Blood Gas Studies[9]

Exhibit #	Physician	Date of Study	Altitude	Resting (R) Exercise (E)	PCO2	PO2	Qualify?	Age	Comments
CX 1	Rasmussen	2/23/06	0-2999 ft[10]	R E	35 38	68 59	No Yes	68	
DX 10	Girish	10/4/04	0-2999 ft	R E	38.8 39.4	82 80	No no	67	
EX 1	Castle	2/22/05	0-2999 ft	R E	38.8 38.7	69.7 82.0	No no	67	Exercise PO2 is within normal limits. Carbyxyhemoglobin level is normal.
EX 3	Hippensteel	6/8/05	0-2999 ft	R E	38.0 37.2	74.1 65.7	No no	67	

Biopsy Evidence

Exhibit Number	Physician	Date of Biopsy Report	Comments
CX 4	Smiddy	6/14/04	"The patient has erythema and edema consistent with bronchitis. Pooled bronchoalveolar lavage submitted to the lab." The bronchoscopic diagnosis is Bronchitis

Other Medical Evidence

Exhibit #	Physician	Type of Record	Date of Report	Summary
CX 5	Lepsch	CT Scan	6/1/04	Lingular density suggesting scarring and mild emphysema. There is a linear density in the lingula of the left lung. This probably represents either focal atelectasis or scarring. No pulmonary nodule is evident. There are scattered lucencies in the upper lungs typical of mild

[9] 20 C.F.R. 718 Appx. C establishes the standards for the administration and interpretation of arterial blood gas studies.

[10] The altitude of this study was not listed on the arterial blood gas study. However I take judicial notice that the elevation of the location of the study, namely 421 Carriage Drive, Beckley, WV, is 2532 feet above sea level. The altitude was determined by a program located at http://nmviewogc.cr.usgs.gov/viewer.htm.

				centrilobular emphysema. No hilar nor mediastinal lesion is evidence.
CX 6	Wiot	CT scan	6/1/04	There is no evidence of CWP. "There is centrilobular emphysema. is air trapping in the right lower lobe. There are two calcified granulomas in the apices, one on the left and once on the right."[11]
EX 14	Wheeler	CT scan		No pneumoconiosis. There is emphysema with decreased right lower lobe lung markings and minimal centrilobular emphysema in the upper lobes. There is a tiny granuloma or calcified granuloma lateral portion of both apices. There are a few tiny linear discoid atelectasis or scars in the left CPA.

Physician Opinions

Dr. Rasmussen (CX 1)

Dr. Rasmussen based his conclusions upon a coal mine employment history of 40 years and a smoking history of half a pack per day for 39 years. (CX 1 at 2). Dr. Rasmussen noted that Miner reported that he had shortness of breath for approximately 15 years. Miner also suffered from a chronic non-productive cough. The x-ray taken in conjunction with Dr. Rasmussen's exam indicated the presence of pneumoconiosis, with a profusion of 1/0 throughout all lung zones. Dr. Rasmussen reported that the "ventilatory function studies revealed moderate, significantly partially reversible airway obstruction." (CX 1 at 3). Dr. Rasmussen also noted that Miner underwent an incremental treadmill study which showed mild hypoxemia and a moderate impairment in oxygen transfer. (CX 1 at 3). Dr. Rasmussen stated that Miner's ventilatory impairment and his impairment in oxygen transfer and hypoxia indicate at least a minimal to moderate loss of lung function. Dr. Rasmussen concluded that Miner did "not retain the ventilatory capacity nor the ability to maintain arterial oxygenation at work levels required by his last regular coal mine job, and he does not retain the pulmonary capacity to perform his last regular coal mine job."

Dr. Rasmussen stated that Miner's history of coal dust exposure was significant and that there were radiographic changes consistent with pneumoconiosis, therefore "it is medically reasonable to conclude the patient has [CWP] which arose from his coal mine employment." Dr. Rasmussen went on to explain that both cigarette smoking and coal dust exposure may cause identical forms of chronic obstructive lung disease. He also commented that the partial reversibility may be indicative of asthma; however this reversibility may also occur in patients with chronic obstructive pulmonary disease (COPD). Dr. Rasmussen opined that although there is no clear way to distinguish between COPD and asthma, symptoms associated with asthma typically begin at a much earlier age than the onset of Miner's symptoms. (CX 1 at 4). Dr. Rasmussen concluded that both Miner's coal dust exposure and cigarette smoking are the major causes of his disabling lung disease and coal dust exposure is a significant contributing factor. (CX 1 at 4).

[11] Dr Wiot opined that "CT is medically acceptable for evaluation of pulmonary problems. CT is beneficial in confirming or denying the presence of simple coal workers' pneumoconiosis, and can be beneficial in recognizing complicated coal workers' pneumoconiosis when it is not evidence on routine chest xrays."

Dr. Rasmussen is a member of numerous specialty boards, including the American Board of Internal Medicine, the American Board of Forensic Examiners, and the American Board of Forensic Medicine. Dr. Rasmussen is a Fellow at the American College of Forensic Examiners and a Senior Disability Analyst and Diplomate at the American Board of Disability Analysts. He is currently practicing at the Division of Pulmonary Medicine at the Rheumatology and Pulmonary Clinic PLLC in Beckley, West Virginia. Dr. Rasmussen is a member of many professional societies including, but not limited to, the American Thoracic Society, the American Medical Association and the American Public Health Association. Dr. Rasmussen was on the Coal Mine Health Research Advisory Committee at the National Institute for Occupational Health (NIOSH) from 1976 through 1983. He also participated in numerous other programs related to Black Lung disease. (CX 1). Dr. Rasmussen is very prolific and wrote many articles pertaining directly to lung impairment in coal miners. (CX 1).

Dr. Girish (DX 10, EX 7, CX 6)

Dr. Girish was chosen to perform the Department of Labor examination; the report of this examination was issued on October 4, 2004. (DX 10). Dr. Girish was deposed on November 17, 2005. (EX 7). Dr. Girish recognized a 40 year coal mine employment history; however he did not determine the exact nature of the job. When asked whether he determined the exact amount of physical exertion involved in Miner's last job, he responded that Miner "says he's severely limited. Even with minimal exertion, he gets very short of breath." (EX 7 at 8). Dr. Girish based his conclusions on a 37 pack year smoking history that ended in 1996. (EX 7 at 8).

Dr. Girish diagnosed Miner with coal workers' pneumoconiosis. Dr. Girish acknowledged that cigarette smoking is generally thought of as a leading cause of respiratory impairment. He also affirmed the contention that obesity can affect an individual's respiratory condition. (EX 7 at 9, 11). However, Dr. Girish still concluded that Miner suffered from coal workers' pneumoconiosis. Although Dr. Girish testified that he did not know the difference between clinical and legal pneumoconiosis, he defined coal workers' pneumoconiosis as a disease developed by "people who are exposed to coal mining and develop respiratory symptoms related to that, which can give rise to just a simple pneumoconiosis, which is just a radiological finding, or it can go on to produce progressive massive fibrosis and emphysema, chronic bronchitis, cancer, etc." (EX 7 at 6).

Dr. Girish clearly indicated that he did not know how to properly fill out an ILO form. But when further questioned, Dr. Girish stated that the nodular changes found in the right upper region were consistent with coal workers' pneumoconiosis.[12] (EX 7 at 15). However, when asked whether he had diagnosed Miner with radiographic coal workers' pneumoconiosis, he replied "I didn't specifically say that he has it, but say it could be a combination of cigarette smoking as well as coal workers' pneumoconiosis." (EX 7 at 16).

Dr. Girish diagnosed Miner with moderately severe COPD. (EX 7 at 19). He opined that this COPD "could be related to the underlying coal worker's exposure." (EX 7 at 19). Dr. Girish suggested that Miner's impairment could be caused by both cigarette smoking and coal

[12] He also clarified later on in the deposition that he saw nodular changes, not fibrotic changes. (EX 7 at 22).

dust exposure, but he was not sure whether the specific damage caused by each could be determined. Dr. Girish reported that Miner was taking Advair and Spiriva, which are typically used to treat emphysema and COPD. He opined that, although in the past it was thought that these medications were more effective in treating a reversible impairment, these medications may show improvement in irreversible disease. (EX 7 at 12). Dr. Girish also stated that Miner's pulmonary function study results do not necessarily indicate impairment due to smoking because both cigarette smoking and coal dust exposure can give rise to the same physiology. (EX 7 at 18). Based upon these studies, Dr. Girish opined that Miner could return to work in a limited capacity, but not do work that required any kind of exertion. He suggested a desk job. (EX 7 at 21).

Dr. Girish is board certified in internal medicine, pulmonary diseases, critical care and sleep. He splits his time equally between a busy sleep practice and a busy pulmonary practice. (EX 7 at 4). Dr. Girish does not typically treat patients for pneumoconiosis. (EX 7 at 6). Dr. Girish published numerous articles and completed a number of presentations about COPD and sleep disorders such as sleep apnea. (DX 10).

Dr. Castle (EX 1; EX 9, EX 10)

Dr. Castle performed a pulmonary evaluation on Miner on February 22, 2005. Dr. Castle based his conclusions in part upon a 35 pack year smoking history and a 40 year coal mine employment history. Dr. Castle noted that Miner was 67 years old, had been having trouble with shortness of breath for 15 years, often had a productive cough of sputum, and experienced wheezing when walking, which worsens around hairsprays and perfumes. (EX 1 at 1). Dr. Castle reported that Miner did not have a history of asthma, pneumonia, tuberculosis, heart trouble or heart attack, although Miner did occasionally suffer from chest pain in his lower lateral ribs. Miner indicated to Dr. Castle that based upon the results from a bronchoscopy, Dr. Smiddy told Miner that he had black lung and bronchitis. Upon physical examination, Dr. Castle reported that Miner had equal breath sounds throughout, though the sounds were somewhat diminished. He reported that Miner had "some prolongation of the breath sounds," but he found no rales, rhonchi, wheezes, rubs, crackles or crepitations. (EX 1 at 2).

Dr. Castle opined that the x-ray taken in conjunction with the exam showed no parenchymal abnormalities consistent with pneumoconiosis. Dr. Castle reported that the pulmonary function studies, which he opined were valid, "showed evidence of moderate, significantly reversible airway obstruction with gas trapping and hyperinflation and a normal diffusing capacity." (EX 1 at 3). Arterial blood gas studies were conducted. The resting study showed that the carboxyhemoglobin level was normal. The exercise study showed that Miner had some hypertension at the end of exercise. Dr. Castle concluded that Miner "did not develop a disabling abnormality related to blood gas transfer mechanisms." (EX 1 at 3).

Based upon the data obtained at the time of his evaluation of Miner, Dr. Castle came to a number of conclusions. He stated that there was "no evidence of [CWP] by physical examination, radiographic evaluation, and physiologic testing." (EX 1 at 3). He did see evidence of a "moderate, significantly reversible airway obstruction with hyperinflation and gas

trapping." (EX 1 at 4). He diagnosed tobacco smoke induced chronic obstructive pulmonary disease.

Dr. Castle also reviewed Miner's claim for benefits and the medical data included therein, Miner's employment history and the description of coal mine work. Based upon his examination of Miner and the review of additional medical data, Dr. Castle concluded that Miner was permanently and totally disabled, but that Miner's disabling pulmonary impairment was not a result of coal mine dust induced lung disease. Miner did not suffer from CWP. He acknowledged that both Miner's coal dust exposure and tobacco abuse are risk factors for pulmonary disease. However, he explained that Miner "did not demonstrate any consistent physical findings indicating the presence of an interstitial pulmonary process. He did not have the consistent finding of rales, crackles, or crepitations." (EX 1 at 5). Dr. Castle found Miner's impairment to be obstructive in nature and significantly reversible. He found gas trapping and hyperinflation. He attributed this obstruction solely to tobacco smoke induced chronic airway obstruction. He stated that "when [CWP] causes impairment, it generally does so by causing a mixed, irreversible obstructive and restrictive ventilatory defect. That was not the finding in this case. Tobacco smoke induced lung disease typically causes airway obstruction without restriction which may have a significant degree of reversibility as is seen in this case." (EX 1 at 5).

Dr. Castle clarified that his opinion regarding the source of Miner's disability would remain unchanged even if Miner was found to have radiographic evidence of simple pneumoconiosis. His opinions regarding the issue were contingent upon Miner not demonstrating the physiologic changes consistent with CWP. (EX 1 at 6).

Dr. Castle was deposed on April 7, 2006. (EX 9). Prior to the deposition, Dr. Castle reviewed the medical reports completed by Drs. Hippensteel, Girish and Rasmussen, as well as the medical records from Pulmonary Associates of Kingsport. (EX 9 at 10). Based upon all the information, Dr. Castle diagnosed Miner with a "moderate airway obstruction with a very significant asthmatic component that has been brought about by his tobacco smoking and bronchial asthma." (EX 9 at 15). Based upon the arterial blood gas studies Dr. Castle noted "variability in the oxygenation over time and with exercise" and attributed this phenomenon to "ventilation/ perfusion mismatching due to his airway obstruction due to smoking and asthma." (EX 9 at 15). The additional data supported his original conclusion that Miner had a respiratory disability. He opined that Miner's impairment was not caused by, related to or aggravated by coal dust exposure or by medical or legal pneumoconiosis. He stated that Miner's "physiologic impairment is that of a moderate, very significantly reversible degree of airway obstruction associated with gas trapping, hyperinflation and on some occasions, reduction in the diffusing capacity." He explained that "those are the findings one would expect with tobacco smoke induced bronchial disease and asthma." (EX 9 at 16). He opined that CWP causes a "mixed irreversible obstructive and restrictive impairment and in fact only very rarely causes a diffusing impairment, and then if it's associated with a high degree of profusion of either letter p or … letter r type opacities, and that was not the finding in this case." (EX 9 at 16).[13]

[13] Dr. Castle also completed a supplemental report dated May 5, 2006. (EX 10). The content of this report is similar to the conclusions and explanations he offered during his deposition.

Dr. Castle is board certified in both internal medicine and pulmonary disease. He practiced medicine with Pulmonary Medicine Associates in Roanoke, Virginia, since 1977. He also practices with the Pulmonary Occupational and Research Consultants. He is licensed to practice in both Virginia and Florida. His practice consists of any and all types of pulmonary disease. (EX 9 at 6). He has acquired a B- Reader certification. Dr. Castle is a member of numerous societies, including the American College of Physicians, The American Thoracic Society and the Medical Society of Virginia. Dr. Castle was a clinical professor of medicine at the University of Virginia, School of Medicine. During medical school, Dr. Castle worked "down in the coal fields of West Virginia, for the Office of Economic Opportunity at that time." (EX 9 at 7). He developed an interest in silicosis, coal workers' pneumoconiosis and the relevant legislation. He has also completed numerous publications, abstracts and presentations, all of which related in some way to pulmonary functioning. (EX 1). However, he has not written anything specifically about pneumoconiosis. (EX 9 at 8).

Dr. Hippensteel (EX 3, EX 5, EX 11)

Dr. Hippensteel examined Miner on June 8, 2005. (EX 3). Dr. Hippensteel questioned Miner with regard to his medical, occupational and social histories. Dr. Hippensteel documented a coal mine employment history of 40 years, twelve of which were underground. Dr. Hippensteel noted that Miner's last job was as a preparation plant operator. (EX 3). Miner reportedly smoked half a pack of cigarettes per day from the age of 24 until 1998, or an 18 pack year smoking history. (EX 5 at 11). Dr. Hippensteel noted that Miner had breathing trouble for approximately 15 years. According to Dr. Hippensteel's report, Miner did not have any known allergies, only gets rare upper respiratory infections, had pneumonia once two years prior, had not been diagnosed with asthma, and had not had tuberculosis exposure or bird exposure. (EX 3). Miner reported having a daily cough that would occasionally produce less than one teaspoon of sputum.

Dr. Hippensteel listened to Miner's lungs during the physical examination and found "minimal rhonchi in bases with reasonably good air movement." (EX 3). Dr. Hippensteel read the chest x-ray to be completely negative for pneumoconiosis with a classification of 0/0. Dr. Hippensteel reported that the spirometry indicated a "mild airflow obstruction pre and post bronchodilator," there was no restriction, however there was gas trapping. "[Miner's] MVV is moderately reduced with variable tidal volumes, making for underestimate of his true function." There was only a mild reduction in diffusion capacity. Blood gas studies were also conducted, however the exercise was stopped due to dyspnea and wheezing. These studies showed no evidence of ischemia. There was a decrease in pO2 during exercise, but still remained in the low normal range.

Dr. Hippensteel also reviewed Miner's claim for black lung benefits. Based upon this review and his findings from Miner's evaluation, Dr. Hippensteel concluded that Miner did "not have coal workers' pneumoconiosis or any more than mild ventilatory impairment from any cause, including his prior coal mine dust exposure." He explained that Miner was on bronchodilators, which would not be a proper treatment for CWP, but would be helpful for treating asthma or smoke induced chronic bronchitis. He stated that "it has been too long since

he stopped work in the mines to consider industrial bronchitis as a possible diagnosis in this man, since industrial bronchitis from coal dust exposure usually subsides in a period of several months after leaving the work in the mines." (EX 3). Dr. Hippensteel concluded that Miner is totally disabled because of "his age, obesity, hypertension, arthritis, and possible sleep apnea, which are unrelated to his prior coal mine dust exposure." (EX 3).

Dr. Hippensteel was deposed on April 3, 2006. Prior to the deposition he reviewed Miner's medical records, which included Dr. Castle's examination report, the Department of Labor examination report completed by Dr. Girish and medical records from Pulmonary Associates of Kingsport and Dr. Smiddy. (EX 5 at 9). Dr. Hippensteel opined that Miner did not suffer from clinical or legal pneumoconiosis. (EX 5 at 15). With reference to the issue of legal pneumoconiosis, Dr. Hippensteel stated that "… he had evidence on exam that he had chronic bronchitis which is a disease of the general public, and he did not have findings that would be indicative of industrial bronchitis from his coal mine dust exposure since that had ceased many years prior to this examination." (EX 5 at 16). Dr. Hippensteel concluded that "all of these findings put together showed that he had chronic bronchitis unrelated to his coal mine dust exposure and that it was something that was not impairing enough to keep him from going back to his previous job in the mines." (EX 5 at 16). He explained that his examination of Miner yielded the finding of a mild, partially reversible air flow obstruction. He opined that such an impairment is not consistent with impairment caused by coal mine dust exposure. In a supplemental report, dated May 2, 2006, Dr. Hippensteel expressed his disagreement with Dr. Rasmussen's statement that one lung disease can not be differentiated from another. Dr. Hippensteel concluded that "this case shows with a reasonable degree of medical certainty that such differentiation can be made and is consistent with disease unrelated to his prior coal mine dust exposure." (EX 11).

Dr. Hippensteel testified that the additional medical evidence supported his conclusion that coal mine dust exposure did not cause a pulmonary impairment in Miner. He explained that most other studies showed active bronchial inflammation. The studies indicated the presence of a reversible impairment, which is "compatible with ongoing bronchitis, even with the possibility of an asthmatic component and neither of these are associated with his prior coal mine dust exposure and may not even be associated with his history of cigarette smoking, since it had ceased a good while back..." (EX 5 at 19).

Dr. Hippensteel is board certified in Internal Medicine with a subspecialty in both pulmonary medicine and critical care medicine. He is a member four professional organizations, which include the American College of Physicians and the American Thoracic Society. Dr. Hippensteel currently works with the Pulmonary Medicine Associates and the Pulmonary Occupational and Research Consultants, both located in Roanoke VA. Although Dr. Hippensteel is not as prolific as Dr. Castle, he did receive numerous honors from the American Lung Association of Virginia. (EX 3). Dr. Hippensteel is a member of the active staff at Roanoke Memorial Hospital and Community Hospital of Roanoke. Currently, he is an associate professor of medicine in the clinical department of the University of Virginia for the Roanoke program teaching internal medicine residents about pulmonary diseases. (EX 5 at 7).

Dr. Smiddy (CX 4)

Dr. Ahmed referred Miner to Dr. Smiddy for an evaluation for yellow cough, wheezing, shortness of breath, orthopnea, emphysema and hypertension. Dr. Smiddy reported his conclusions in a consultation letter dated May 28, 2004. Dr. Smiddy noted that Miner worked in mining for 42 years, 25 of which were on a preparation plant, and a smoking history of 43 years, although he doesn't specify the amount smoked per day. Upon physical examination, Dr. Smiddy found patient's chest to be clear without rales, rubs or rhonchi. An x-ray was taken in conjunction with the evaluation. Dr. Smiddy reported that the x-ray showed "slight prominence of markings in the lingula with evidence of pneumoconiosis." Based on the evaluation, Dr. Smiddy diagnosed "CWP, COPD, lingular scarring, some rounded densities that are not clearly calcified." (CX 4).

Dr. Smiddy is board certified in internal medicine.[14] He is currently a partner at Pulmonary Associates in Kingsport, Tennessee. Dr. Smiddy is a member of the American Thoracic Society, the Tennessee Medical Association and the Sullivan County Medical Society. In 1982 he was chairman of the Occupational Lung Disease Symposium in connection with the American Lung Association of Tennessee and in 1982 – 1984 he was the Vice President of the American Lung Association of Tennessee. Dr. Smiddy has participated in multiple conferences, grand rounds and seminars on a broad variety of pulmonary topics including pneumoconiosis, COPD and asthma. He has also published numerous articles, most of which pertain to fiberoptic bronchoscopy. (CX 4).

Hospital and Treatment Records

Dr. Smiddy (CX 4)

In a progress note dated June 8, 2004, Dr. Smiddy diagnosed Miner with pneumoconiosis, lingular scarring and COPD. (CX 4). Miner returned to Dr. Smiddy on June 21, 2004. The progress note does not report any significant changes from the previous visit. The diagnoses included CWP, COPD and chronic bronchitis. (CX 4). The October 19, 2004 treatment record indicated that no changes occurred between June and October of 2004. The diagnoses included old pneumonia, as well as CWP and COPD. (CX 4).

Miner received a bronchoscopy on June 14, 2004. (CX 4). The bronchial washing specimen was negative for malignancy. The cytology report indicated that the samples were negative for malignancy and diagnosed "bronchial cells. Macrophages. Acute inflammation." (CX 4). The cytology slides were not released, as according to policy at Highlands Pathology Consultants, P.C. Dr. Adelson opined that these slides would not be helpful in determining the presence of black lung. (EX 4).

[14] I take judicial notice of board certification in internal medicine. The American Board of Medical Specialties provides this information at http://www.abms.org/searchdetail.asp?key=61893.

DISCUSSION

Because Claimant filed his application for benefits after March 31, 1980, this claim shall be adjudicated under the regulations at 20 C.F.R. Part 718. Also, since this claim was filed after January 19, 2001, the regulations contained in 20 C.F.R. Part 718[15] as amended in 2001 are applicable. To establish entitlement to benefits under this part of the regulations, a claimant must prove by a preponderance of the evidence that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, that he is totally disabled, and that his total disability is due to pneumoconiosis. 20 C.F.R. §725.202(d); Anderson v. Valley Camp of Utah, Inc., 12 BLR 1-111, 1-112 (1989). In Director, OWCP v. Greenwich Collieries, et al., the U.S. Supreme Court stated that where the evidence is equally probative, the claimant necessarily fails to satisfy his burden of proving the existence of pneumoconiosis by a preponderance of the evidence. 114 S. Ct. 2251 (1994). Although Miner currently lives in Tennessee, his coal mine employment took place in Virginia, and therefore the rulings of the United States Court of Appeals for the Fourth Circuit control in the adjudication of this case.

Pneumoconiosis

Under the Act, "'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b). "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment. §718.201(a)(1-2).

Section 718.202(a) provides four methods for determining the existence of pneumoconiosis, (1) x-ray evidence; (2) biopsy or autopsy evidence; (3) if applicable, the presumptions described in §§ 718.304, 718.305 or § 718.306 and (4) physician opinion evidence. Under § 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence. In evaluating the x-ray evidence, I assign heightened weight to interpretations of physicians who qualify as either a board-certified radiologist or "B" reader. Dixon v. North Camp Coal Co., 8 BLR 1-344, 1-345 (1985). I assign greatest weight to interpretations of physicians with both of these qualifications. Woodward v. Director, OWCP, 991 F.2d 314, 316 n.4 (6th Cir. 1993); Sheckler v. Clinchfield Coal Co., 7 BLR 1-128, 1-131 (1984).

This claim includes nine interpretations of five x-rays. The February 23, 2006 x-ray was interpreted by four physicians, three of which were dually qualified specialists[16] and the

[15] All of the regulations cited in this decision are contained in Title 20 of the Code of Federal Regulations.
[16] A dually qualified specialist is both a B-reader and a board certified radiologist.

remaining physician was a B-reader. Drs. Wiot and Spitz, both dually qualified specialists, interpreted this x-ray to be negative for pneumoconiosis. Dr. Westerfield, also a dually qualified specialist, read this x-ray as positive for pneumoconiosis with a profusion of 1/1. Dr. Rasmussen is not board certified in radiology; however he is a B-reader. He interpreted this x-ray as positive for pneumoconiosis with a profusion of 1/0, which is the lowest profusion that would qualify as a positive reading of pneumoconiosis. The consensus between two dually qualified specialists outweighs the consensus between a dually qualified specialist and a B-reader. I find this x-ray to be negative for pneumoconiosis.

The x-rays dated February 22, 2005 and June 8, 2005 were both interpreted to be negative for pneumoconiosis. Both Drs. Wiot and Girish reviewed the x-ray dated September 28, 2004. Dr. Wiot is more qualified with a board certification in radiology and a B-reader certificate. Dr. Girish is neither board certified nor a B-reader. Dr. Girish opined that this x-ray indicated the presence of pneumoconiosis. However, he circled two different profusion levels on the ILO form.[17] I find his interpretation to be equivocal. Dr. Wiot interpreted the x-ray to be completely negative for pneumoconiosis. I find this x-ray to be negative for pneumoconiosis.

Dr. Smiddy provided a narrative interpretation of the x-ray dated May 28, 2004, in which he opined that this x-ray showed evidence of pneumoconiosis. I find this x-ray to be positive for pneumoconiosis. This is the sole x-ray of the five x-ray included in the record that indicates the presence of pneumoconiosis, and was interpreted by a physician that is not a board certified radiologist or a B-reader. Overall, I find that Claimant has not established the presence of pneumoconiosis through radiographic evidence under 20 C.F.R. §718.202(a)(1).

Under § 718.202(a)(2), a claimant may establish pneumoconiosis through biopsy evidence. The biopsy evidence in this case indicates the presence of bronchitis, but does not show changes consistent with clinical pneumoconiosis. I therefore find that the biopsy evidence does not establish the presence of pneumoconiosis.

Under § 718.202(a)(3), a claimant may prove the existence of pneumoconiosis if one of the presumptions at §§ 718.304 to 718.306 applies. The presumptions at §§ 718.305 and 718.306 are inapplicable because they only apply to claims that were filed before January 1, 1982, and June 30, 1982, respectively. Section 718.304 requires x-ray, biopsy, or equivalent evidence of complicated pneumoconiosis. Complicated pneumoconiosis is diagnosed after a finding of an opacity greater than one centimeter is categorized as a type A, B or C. There is no mention of complicated pneumoconiosis in the medical evidence in the record; therefore I find this presumption to be inapplicable.

[17] During his deposition, he admitted that he did not entirely understand the format of the ILO form, however he did opine that the x-ray showed nodular changes consistent with CWP. However, when asked whether he had diagnosed Miner with radiographic coal workers' pneumoconiosis, he replied "I didn't specifically say that he has it, but say it could be a combination of cigarette smoking as well as coal workers' pneumoconiosis." (EX 7 at 16).

The final method by which Claimant can establish that he suffers from the disease is by well- reasoned, well-documented medical reports as per §718.202(a)(4). A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's history. Hoffman v. B&G Construction Co., 8 B.L.R. 1-65 (1985); Hess v. Clinchfield Coal Co., 7 B.L.R. 1-295 (1984). A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation adequate to support the physician's conclusions. Fields, supra. Indeed, whether a medical report is sufficiently documented and reasoned is for the administrative law judge as the finder-of-fact to decide. Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989)(en banc). Moreover, statutory pneumoconiosis is established by well-reasoned medical reports which support a finding that the miner's pulmonary or respiratory condition is significantly related to or substantially aggravated by coal dust exposure. Wilburn v. Director, OWCP, 11 B.L.R. 1-135 (1988). Medical opinion evidence may establish either clinical or legal pneumoconiosis.

Clinical Pneumoconiosis

Based on the February 23, 2006 x-ray, Dr. Rasmussen concluded that Miner suffered from simple coal workers' pneumoconiosis. Dr. Rasmussen had read that x-ray to be positive for pneumoconiosis, which is contrary to the finding of the Court. It is proper for the administrative law judge to accord less weight to a physician's opinion that is based on premises contrary to the judge's findings. Furgerson v. Jericol Mining, Inc., 22 B.L.R. 1-216 (2002)(en banc) (the ALJ 'did not reconcile (a) physician's diagnosis of pneumoconiosis, based upon the positive x-ray and the miner's significant duration of coal dust exposure, with the fact that Dr. Baker's positive interpretation was reread as negative by a physician with superior qualifications'; as a result, the Board directed that the ALJ 'address whether this rereading impacts the physician's opinion and his diagnosis of pneumoconiosis'). Dr. Rasmussen provided no other explanation for the diagnosis of clinical coal workers' pneumoconiosis. Therefore, I find Dr. Rasmussen's opinion regarding this issue to be of little probative value.

It is unclear as to whether Dr. Girish concluded that Miner showed radiographic evidence of clinical pneumoconiosis. At one point in his deposition he indicated that he found nodular changes consistent with pneumoconiosis, but he later testified that he did not definitively believe that there was radiographic evidence of clinical pneumoconiosis in this case. I find Dr. Girish' opinion to be internally inconsistent. A report may be given little weight where it is internally inconsistent and inadequately reasoned. Mabe v. Bishop Coal Co., 9 B.L.R. 1-67 (1986). I grant Dr. Girish's opinion little weight.

Dr. Smiddy opined that the evidence in this case established the presence of CWP. The adjudication officer must give consideration to the relationship between the miner and any treating physician whose report is admitted into the record. 20 C.F.R. 718.104(d). In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating

physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole. 20 C.F.R. 718.104(d)(5). Dr. Smiddy based his conclusions pertaining to the presence of clinical pneumoconiosis primarily on the May 28, 2004 x-ray. This is the only x-ray that shows the presence of pneumoconiosis. And I have already determined that the x-ray evidence as a whole does not establish the presence of pneumoconiosis. The only other explanation for Dr. Smiddy's diagnosis is the fact that Miner worked in the coal mine industry for a period of time, which standing alone does not establish the presence of clinical pneumoconiosis.[18]

Drs. Hippensteel and Castle both concluded that there was no evidence of clinical pneumoconiosis. Their conclusions are supported by the Court's finding that there is no radiographic evidence of CWP. Drs. Hippensteel and Castle are both more qualified to recognize radiographic changes consistent with pneumoconiosis as both physicians are B-readers, whereas Dr. Smiddy is not. Although Dr. Smiddy is Miner's treating physician, I find the opinions of Drs. Hippensteel and Castle to be most persuasive on this issue.

The consensus between Drs. Hippensteel and Castle is also supported by the CT scan evidence. Every CT scan showed evidence of emphysema. Drs. Wiot, Wheeler and Lepsch interpreted the June 1, 2004 CT scan. Both Drs. Wiot and Wheeler opined that this there was no evidence of CWP. Dr. Lepsch noted a lingular density that he attributed to scarring. He commented that there was no pulmonary nodule. Dr. Smiddy reported that the "prior CT of the chest showed lingular density with scarring and mild emphysema." Not one of the physicians specifically diagnosed CWP. I find that the CT scan evidence does not support a finding clinical pneumoconiosis.

Legal Pneumoconiosis

Every physician diagnosed Miner with some sort of obstructive impairment including chronic bronchitis, asthma, emphysema and COPD. A pulmonary disease may constitute statutory pneumoconiosis if it is significantly related to or aggravated by coal dust exposure in coal mine employment. The legal definition of pneumoconiosis is broad and may encompass more respiratory or pulmonary conditions than those specifically, clinically diagnosed in a medical opinion. For example, a physician may conclude that the miner suffers from asthma that is related to his coal dust exposure. Although the physician did not specifically state that the miner suffered from pneumoconiosis or black lung disease, the respiratory condition that he diagnoses is related to coal dust exposure and, therefore, is supportive of a finding of legal pneumoconiosis. Any of the above diagnoses could potentially fit the definition of legal pneumoconiosis, so long as the physician relates the diagnosis to coal dust exposure.

Dr. Rasmussen stated that Miner's obstructive impairment could either be caused by asthma or COPD, but either way, he concluded that both cigarette smoking and coal dust

[18] Dr. Smiddy provided the majority of treatment notes found in the record. Throughout these notes, he diagnoses CWP, however he provides no further explanation other that what is noted above. The remaining treatment records are of little probative value with regards to the presence of clinical pneumoconiosis.

exposure were contributing factors. He opined that smoking and coal dust exposure cause identical forms of COPD. That is the extent of Dr. Rasmussen's explanation. This conclusion could be made in any case where a Miner had COPD. A medical opinion based upon generalities, rather than specifically focusing upon the miner's condition, may be rejected. Knizer v. Bethlehem Mines Corp., 8 B.L.R. 1-5 (1985). I therefore find Dr. Rasmussen's opinion to be of little probative value in the analysis of whether Miner suffers from legal pneumoconiosis.

Dr. Girish stated that COPD "*could* be related to the underlying coal worker's exposure." (emphasis added). (EX 7 at 19). When asked whether cigarette smoking could be the sole cause of Miner's impairment, Dr. Girish responded "couldn't say, could be a combination." (EX 7 at 19). I find Dr. Girish's opinion to be equivocal. An opinion may be given little weight if it is equivocal or vague. Griffith v. Director, OWCP, 49 F.3d 184 (6th Cir. 1995) (treating physician's opinion entitled to little weight where he concluded that the miner 'probably had black lung disease)[19]. I therefore grant Dr. Girish's opinion diminished weight.

Dr. Smiddy diagnosed clinical pneumoconiosis. I have already ruled out the presence of clinical pneumoconiosis. Although Dr. Smiddy also diagnosed COPD, he did not relate this finding to coal dust exposure. Dr. Smiddy's opinion and treatment notes are not probative on the issue of legal pneumoconiosis.

Dr. Castle attributed Miner's impairment solely to cigarette smoking. Dr. Castle explained that "tobacco smoke induced lung disease typically causes airway obstruction without restriction which may have a significant degree of reversibility as is seen in this case." (EX 1 at 5). He also mentioned that the gas trapping, hyperinflation and occasional reduction in diffusing capacity found in this case were indicative of smoke induced bronchial disease and asthma. He specifically supported this contention with the results from the arterial blood gas studies; Dr. Castle commented that "variability in the oxygenation over time and with exercise" and attributed this phenomenon to "ventilation/ perfusion mismatching due to his airway obstruction due to smoking and asthma." (EX 9 at 15). He also noted that the physical findings typically associated with interstitial pulmonary process, namely rales, crackles or crepitations, were not present in this case. Dr. Castle's opinion is both well documented and well reasoned. He conducted a physical examination and reviewed other medical evidence found in the record. He supports his conclusions with the underlying medical data. Dr. Castle did base his conclusions on a 35 pack year smoking history. I determined Miner's smoking history to be 27 pack years. It is proper for an ALJ to grant a medical opinion less weight if based upon an inaccurate smoking history. Trumbo v. Reading Anthracite Co., 17 B.L.R. 1-85 (1993). While I still find Dr. Castle's conclusions to be probative on this issue, I do slightly diminish the weight I credit his opinion.

Dr. Hippensteel diagnosed Miner with tobacco induced bronchitis. Dr. Hippensteel disagreed with Dr. Rasmussen that one lung disease could not be differentiated from another. He

[19] Although case law in the Sixth Circuit is not binding in this case, I find the reasoning in Griffith to be applicable and persuasive in this case.

opined that "this case shows with a reasonable degree of medical certainty that such differentiation can be made and is consistent with disease unrelated to his prior coal mine dust exposure." (EX 11). Dr. Hippensteel opined that a mild, yet reversible, obstructive impairment, as seen in this case, is not consistent with changes caused by coal dust exposure. He explained that Miner's "hypoxemia is variable and is not secondary to a diffusion impairment as one would expect with coal workers' pneumoconiosis and this variability is often unexpected with coal workers' pneumoconiosis which should cause a fixed and permanent impairment as a consequence of that disease." (EX 11). This explanation effectively rebuts Dr. Rasmussen's conclusions.[20] Dr. Hippensteel reported that Miner had an 18 pack year smoking history, which is 9 years less than the smoking history determined by the court. Although I typically grant an opinion that is based on an inaccurate smoking history less weight, I will not do so in this instance. Despite underestimating Miner's smoking history, Dr. Hippensteel still concluded that Miner did not have legal pneumoconiosis. I can't imagine that an a greater smoking history would induce Dr. Hippensteel to decide that Miner's impairment was in fact related to coal dust exposure. I would be more concerned if Dr. Hippensteel had underestimated Miner's coal mine employment. I therefore find that Dr. Hippensteel's deflated estimation of Miner's smoking history has no bearing on the credibility of his opinion.

Dr. Castle is board certified in internal medicine and pulmonary disease and expressed an interest in silicosis, CWP and relevant legislation. He has written numerous pulmonary function related articles. However, he has never written an article about pneumoconiosis. Dr. Rasmussen is a member of numerous specialty boards, including the American Boards of internal medicine, forensic examiners and forensic medicine. He participated in many programs related to Black Lung disease. Dr. Girish is board certified in internal medicine, pulmonary diseases, critical care and sleep. Although he does not typically treat patients with pneumoconiosis, he has published numerous articles pertaining to COPD. Dr. Hippensteel is board certified in internal medicine with a subspecialty in both pulmonary medicine and critical care medicine. Though not as prolific as Dr. Castle, he did receive numerous honors from the American Lung Association of Virginia. Dr. Smiddy is board certified in internal medicine. Dr. Smiddy has participated in a number of conferences on a variety of topics, including pneumoconiosis and COPD. All physicians in this case are well qualified. I find that Drs. Castle, Rasmussen, Hippensteel and Smiddy have experience treating and diagnosing pneumoconiosis. Neither Drs. Rasmussen nor Smiddy possess board certification in pulmonary medicine, however they have written articles,

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[20] Dr. Hippensteel also made the distinction between chronic bronchitis and industrial bronchitis. He explained that "it has been too long since he stopped work in the mines to consider industrial bronchitis as a possible diagnosis in this man, since industrial bronchitis from coal dust exposure usually subsides in a period of several months after leaving the work in the mines." (EX 3). He concluded that Miner suffered from chronic bronchitis, "which is a disease of the general public." (EX 5 at 16). Dr. Hippensteel seemed to infer that Miner's chronic bronchitis was not due to coal dust exposure because chronic bronchitis was a disease of the general population. Although the observation that chronic bronchitis is a disease of the general population *may* rule out the possibility that coal dust exposure is a necessary precursor to the manifestation of the disease, it doesn't rule out the possibility that the disease was aggravated by Miner's exposure to coal dust. The amended regulations specifically provide that "a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. §718.201(b) (2001). I find Dr. Hippensteel's commentary specific to the presence and cause of chronic bronchitis to be of little probative value in the analysis of the presence of legal pneumoconiosis.

attended conferences and given presentations directly related to pneumoconiosis. Their greater pertinent experience does not outweigh the lack of reasoning in their respective opinions.

I rely on the consensus between Drs. Castle and Hippensteel. I find that the preponderance of the probative medical opinion evidence did not support a finding of legal pneumoconiosis.

Miner did not establish the presence of clinical or legal pneumoconiosis; therefore the other three elements of establishment are moot. The preponderance of the evidence does not support a finding of pneumoconiosis, therefore Miner's claim for benefits must be denied.

ORDER

J.O.'s claim for benefits under the Act is hereby **DENIED.**

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LARRY W. PRICE
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).